		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010561

Facility Name: Knox County Nursing Home

Address: P.O. Box 219, 800 N. Market Street (Number) Knoxville (City) 61448 (Zip Code)

County: Knox

Telephone Number: (309) 289-2338 **Fax #** (309) 289-8384

IDPA ID Number: 376001167801

Date of Initial License for Current Owners: 10/23/46

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/01 to 11/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,246	4,148	3,923	21,317	8
9	SNF/PED					9
10	ICF	29,630	13,306		42,936	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,876	17,454	3,923	64,253	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.29%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/28/66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,923

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/02 Fiscal Year: 11/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	386,587	31,925	8,368	426,880		426,880		426,880			1
2	Food Purchase		366,288		366,288		366,288	(1,438)	364,850			2
3	Housekeeping	248,684	50,245		298,929		298,929		298,929			3
4	Laundry	192,412	28,637		221,049		221,049		221,049			4
5	Heat and Other Utilities			224,615	224,615		224,615		224,615			5
6	Maintenance	112,326	6,544	184,107	302,977		302,977	(324)	302,653			6
7	Other (specify):*											7
8	**TOTAL General Services**	940,009	483,639	417,090	1,840,738		1,840,738	(1,762)	1,838,976			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	3,208,924	232,071	19,746	3,460,741		3,460,741	(2,538)	3,458,203			10
10a	Therapy			177,447	177,447		177,447		177,447			10a
11	Activities	132,185	7,443	2,206	141,834		141,834		141,834			11
12	Social Services	142,930	495	2,206	145,631		145,631		145,631			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,484,039	240,009	208,805	3,932,853		3,932,853	(2,538)	3,930,315			16
	C. General Administration											
17	Administrative	127,052			127,052		127,052		127,052			17
18	Directors Fees			3,122	3,122		3,122		3,122			18
19	Professional Services			34,149	34,149		34,149	(1,534)	32,615			19
20	Dues, Fees, Subscriptions & Promotions			20,714	20,714		20,714	(270)	20,444			20
21	Clerical & General Office Expenses	168,184	15,818	24,975	208,977		208,977	22,581	231,558			21
22	Employee Benefits & Payroll Taxes			570,586	570,586		570,586	463,311	1,033,897			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,126	8,126		8,126	(1,471)	6,655			24
25	Other Admin. Staff Transportation			4,983	4,983		4,983		4,983			25
26	Insurance-Prop.Liab.Malpractice			24,578	24,578		24,578		24,578			26
27	Other (specify):*											27
28	**TOTAL General Administration**	295,236	15,818	691,233	1,002,287		1,002,287	482,617	1,484,904			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,719,284	739,466	1,317,128	6,775,878		6,775,878	478,317	7,254,195			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Knox County Nursing Home #0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			139,525	139,525		139,525		139,525			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,519	2,519		2,519		2,519			35
36	Other (specify):*											36
37	**TOTAL Ownership**			142,044	142,044		142,044		142,044			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	21,735	266,639	14,604	302,978		302,978		302,978			39
40	Barber and Beauty Shops	18,288	1,149		19,437		19,437		19,437			40
41	Coffee and Gift Shops			12,322	12,322		12,322		12,322			41
42	Provider Participation Fee			111,481	111,481		111,481		111,481			42
43	Other (specify):* Nonallowable Costs			43,102	43,102		43,102	(43,102)				43
44	**TOTAL Special Cost Centers**	40,023	267,788	181,509	489,320		489,320	(43,102)	446,218			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,759,307	1,007,254	1,640,681	7,407,242		7,407,242	435,215	7,842,457			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,096)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(36,006)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,794)	21		28
29	Other-Attach Schedule See Pg5A	(8,317)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,213)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	489,428		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 489,428		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 435,215		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/01/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal fees- out of period	$ (407)	19	1
2	Legal fees- collections	(332)	19	2
3	Non-allowable travel expenses	(1,471)	24	3
4	To offset insurance revenue	(262)	22	4
5	To offset dues & subscriptions revenue	(270)	20	5
6	To offset Food revenue	(1,438)	2	6
7	To offset office supply revenue	(480)	21	7
8	To offset medical supply revenue	(2,538)	10	8
9	Non-allowable accounting fees	(795)	19	9
10	To offset reimbursements	(324)	6	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,317)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,438)	0	0	0	0	0	0	0	0	0	0	(1,438)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(324)	0	0	0	0	0	0	0	0	0	0	(324)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,762)	0	0	0	0	0	0	0	0	0	0	(1,762)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,538)	0	0	0	0	0	0	0	0	0	0	(2,538)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,538)	0	0	0	0	0	0	0	0	0	0	(2,538)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,534)	0	0	0	0	0	0	0	0	0	0	(1,534)	19
20	Fees, Subscriptions & Promotions	(270)	0	0	0	0	0	0	0	0	0	0	(270)	20
21	Clerical & General Office Expenses	(3,274)	25,855	0	0	0	0	0	0	0	0	0	22,581	21
22	Employee Benefits & Payroll Taxes	(262)	463,573	0	0	0	0	0	0	0	0	0	463,311	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,471)	0	0	0	0	0	0	0	0	0	0	(1,471)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,811)	489,428	0	0	0	0	0	0	0	0	0	482,617	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,111)	489,428	0	0	0	0	0	0	0	0	0	478,317	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(43,102)	0	0	0	0	0	0	0	0	0	0	(43,102)	43
44	**TOTAL Special Cost Centers**	(43,102)	0	0	0	0	0	0	0	0	0	0	(43,102)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(54,213)	489,428	0	0	0	0	0	0	0	0	0	435,215	45

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Knox County	100%	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bookkeeping and Accounting	$	Knox County	100.00%	$ 25,855	$ 25,855	1
2	V	22	Employee Benefits-IMRF		Knox County	100.00%	106,174	106,174	2
3	V	22	Employee Benefits-FICA		Knox County	100.00%	357,399	357,399	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 489,428	$ * 489,428	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	W. Abel	Board Member	Administrative	0.00	0			Per diem	$ 627	L18, C3	1
2	L. Mannhardt	Board Member	Administrative	0.00	0			& Mileage	455	L18, C3	2
3	M. Diefendorf	Board Member	Administrative	0.00	0				423	L18, C3	3
4	S. Johnson	Board Member	Administrative	0.00	0				457	L18, C3	4
5	G. Keiser	Board Member	Administrative	0.00	0				481	L18, C3	5
6	L. Myers	Board Member	Administrative	0.00	0				405	L18, C3	6
7	S. Keener	Board Member	Administrative	0.00	0				274	L18, C3	7
8											8
9	Note: No members of the County Board provided direct services to the nursing home. In addition, no Board member had ownership in an entity that conducted										9
10		business transactions with the nursing home during the reporting period.									10
11											11
12											12
13								TOTAL	$ 3,122		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Knox County
Street Address: 200 S. Cherry Street
City / State / Zip Code: Galesburg, IL 61401
Phone Number: (309) 345-3837
Fax Number: (309) 343-7002

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bookkeeping & Payroll	Hours Worked	2,166	2166	$ 25,855	$	2,166	$ 25,855	1
2	22	Employee Benefits-IMRF	Direct Cost	1	1				106,174	2
3	22	Employee Benefits-FICA	Direct Cost	1	1				357,399	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 25,855	$		$ 489,428	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3				N/A								3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

NOT APPLICABLE, COUNTY HOME DOES NOT PAY REAL ESTATE TAX

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Knox County Nursing Home COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0010561

CONTACT PERSON REGARDING THIS REPORT Ben Perkins, Administrator

TELEPHONE (309) 289-2338 FAX #: (309) 289-8384

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.	County Home does not pay		$	$
5.	real estate tax.		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 100,375 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	1,481,040	1966	$ 156,600	1
2					2
3	TOTALS	1,481,040		$ 156,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204		1966	1966	$ 1,842,192	$ 36,844	50	$ 36,844	$	$ 1,335,672	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1966 Land Improvements			1966	46,724	934	50	934		33,053	9
10	1971 Additions			1971	152,822		20			152,822	10
11	1980 Additions			1980	15,242		20			15,242	11
12	1981 Additions			1981	650		20			650	12
13	1983 Additions			1983	14,762	217	20	217		14,598	13
14	1984 Additions			1984	31,009	771	20	771		27,691	14
15	1985 Additions			1985	106,261	4,078	20	4,078		97,594	15
16	1986 Additions			1986	141,506	3,010	20	3,010		140,657	16
17	1987 Additions			1987	143,424	5,777	15	5,777		138,128	17
18	1988 Additions			1988	69,882	3,017	20	3,017		45,975	18
19	1989 Additions			1989	37,676	2,380	15	2,380		31,657	19
20	1990 Additions			1990	29,117	1,287	20	1,287		15,953	20
21	1991 Additions			1991	175,965	10,590	15	10,590		133,676	21
22	1992 Additions			1992	232,540	15,334	15	15,334		160,970	22
23	1993 Additions			1993	43,687	3,091	15	3,091		33,383	23
24	1994 Additions			1994	115,370	7,700	15	7,700		68,682	24
25	1995 Additions			1995	68,274	4,618	15	4,618		45,131	25
26	1996 Additions			1996	82,777	5,378	15	5,378		42,094	26
27	1997 Additions			1997	37,834	3,408	15	3,408		18,610	27
28	Bed Lights			1998	3,524	352	10	352		1,703	28
29	Parts for call system			1998	450	45	10	45		180	29
30	Fish Pond			1998	2,629	175	15	175		788	30
31	Garage Door			1998	1,110	74	15	74		345	31
32	Door alarm equipment			1998	596	60	10	60		279	32
33	Fire eye controls			1998	1,110	74	15	74		345	33
34	Fire eye controls			1998	545	36	15	36		163	34
35	Chiller Improvements			1998	1,503	100	15	100		1,261	35
36	Air conditioner			1998	5,217	348	15	348		1,420	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Oil pump for compressor	1998	$ 676	$ 45	15	$ 45	$	$ 582	37
38	New pumps	1998	1,298	87	15	87		1,126	38
39	Boiler improvements	1998	3,195	213	15	213		852	39
40	Boiler repairs	1998	475	32	15	32		148	40
41	Install fire eye	1998	182	12	15	12		56	41
42	Hot water storage tank	1998	11,904	595	20	595		2,529	42
43	Plumbing upgrades	1998	4,286	214	20	214		893	43
44	Compressor improvement	1998	1,333	89	15	89		370	44
45	Coil replacement	1998	1,048	70	15	70		291	45
46	Laundry room ventilation	1999	3,246	216	15	216		964	46
47	Steam generated tanks	1999	13,865	924	15	924		4,120	47
48	Pump	1999	924	92	10	92		277	48
49	Air conditioner	1999	2,476	248	10	248		743	49
50	Freezer compressor	2000	2,321	232	10	232		658	50
51	Air conditioner	2000	2,810	281	10	281		632	51
52	Exhaust Fan	2000	1,500	150	10	150		313	52
53	Hot water heater	2000	13,865	1,387	10	1,387		4,160	53
54	Fireplace	2001	1,395	140	10	140		152	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,471,197	$ 114,725		$ 114,725	$	$ 2,577,588	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 280,913	$ 20,767	$ 20,767	$	10-15	$ 172,105	71
72	Current Year Purchases	150,455	4,033	4,033		10	4,033	72
73	Fully Depreciated Assets	327,648					327,648	73
74								74
75	TOTALS	$ 759,016	$ 24,800	$ 24,800	$		$ 503,786	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van	1992	$ 38,295	$	$	$	4	$ 38,295	76
77	Resident Care	Ford Escort Wagon	1993	10,827				4	10,827	77
78	Resident Care	Ford Truck	1995	17,024				4	17,024	78
79										79
80	TOTALS			$ 66,146	$	$	$		$ 66,146	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,452,959	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 139,525	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,525	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,147,520	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 2,519 Description: Dish Machine $2,519
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs		$	3,833	$ 57,502	$	3,833	$ 57,502	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			2,250	33,763		2,250	33,763	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs			4,884	73,266		4,884	73,266	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescrpts					253,339		253,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program	39(1, 2, 3)	1150 hrs		21,735	974	14,604	13,300	2,124	49,639	12
13	Other (specify):										13
14	TOTAL				$ 21,735	11,941	$ 179,135	$ 266,639	13,091	$ 467,509	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home
Provider #: 0010561
12/01/01 to 11/30/02

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 759,209	$ 759,209	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	1,056,826	1,056,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,246	27,246	6
7	Other Prepaid Expenses	500	500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,843,781	$ 1,843,781	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,763	13,763	12
13	Land	156,600	156,600	13
14	Buildings, at Historical Cost	3,471,197	3,471,197	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	825,162	825,162	16
17	Accumulated Depreciation (book methods)	(3,147,520)	(3,147,520)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,319,202	$ 1,319,202	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,162,983	$ 3,162,983	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,492	$ 140,492	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	223,783	223,783	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Other Funds	14,879	14,879	36
37	Assessment Tax Payable	18,564	18,564	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 397,718	$ 397,718	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 397,718	$ 397,718	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,765,265	$ 2,765,265	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,162,983	$ 3,162,983	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,575,783	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,575,783	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	189,482	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 189,482	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,765,265	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,916,134	1
2	Discounts and Allowances for all Levels	(82,409)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,833,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,865	6
7	Oxygen	9,468	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 25,333	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	11,790	12
13	Barber and Beauty Care	4,726	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,749	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	65,435	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 154,700	23
	D. Non-Operating Revenue		
24	Contributions	3,776	24
25	Interest and Other Investment Income***	4,261	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,037	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See Schedule 19A**	29,012	28
28a	**Tax Referendum Receipts**	545,917	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 574,929	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,596,724	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,840,738	31
32	Health Care	3,932,853	32
33	General Administration	1,002,287	33
	B. Capital Expense		
34	Ownership	142,044	34
	C. Ancillary Expense		
35	Special Cost Centers	377,839	35
36	Provider Participation Fee	111,481	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,407,242	40
41	**Income before Income Taxes (line 30 minus line 40)****	189,482	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 189,482	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**
Filed as part of the County return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Knox County Nursing Home
Facility #: 0010561
11/30/2002 **Schedule 19A**

Page 19: Line 28 - Other

NSF check charges	145
Transportation income	5,820
Insurance reimbursement-medical supplies	2,538
Reimbursed food cost	1,428
Reimbursed office expense	480
Refund of dues	270
Return of employee insurance premium	262
Duplicate payment - repairs	324
Miscellaneous	17,745
Total Line 28	29,012

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 63,116	$ 30.34	1
2	Assistant Director of Nursing	2,000	2,080	49,388	23.74	2
3	Registered Nurses	22,407	23,303	440,527	18.90	3
4	Licensed Practical Nurses	46,445	48,303	670,778	13.89	4
5	Nurse Aides & Orderlies	160,758	167,188	1,851,364	11.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,114	2,199	28,956	13.17	8
9	Activity Director	2,281	2,372	26,152	11.03	9
10	Activity Assistants	11,302	11,754	106,033	9.02	10
11	Social Service Workers	13,506	14,046	142,930	10.18	11
12	Dietician					12
13	Food Service Supervisor	2,220	2,309	28,288	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,574	40,117	320,342	7.99	15
16	Dishwashers	6,186	6,433	37,957	5.90	16
17	Maintenance Workers	7,082	7,365	112,326	15.25	17
18	Housekeepers	26,569	27,632	248,684	9.00	18
19	Laundry	21,761	22,631	192,412	8.50	19
20	Administrator	2,276	2,367	84,843	35.84	20
21	Assistant Administrator	2,000	2,080	42,209	20.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,989	16,629	168,184	10.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,989	2,069	18,130	8.76	31
32	Other Health Ca See Sch. 20A	10,652	11,078	108,400	9.79	32
33	Other(specify) Barber & Beauty	2,041	2,123	18,288	8.61	33
34	TOTAL (lines 1 - 33)	400,152	416,158	$ 4,759,307 *	$ 11.44	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	256	$ 8,368	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant	15	1,560	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,328	L10, C3	39
40	Physical Therapy Consultant	133	6,372	L10A, C3	40
41	Occupational Therapy Consultant	123	5,535	L10A, C3	41
42	Respiratory Therapy Consultant	3	132	L10A, C3	42
43	Speech Therapy Consultant	20	877	L10A, C3	43
44	Activity Consultant	37	2,206	L11, C3	44
45	Social Service Consultant	38	2,206	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	625	$ 48,784		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Knox County Nursing Home
Provider # 0010561

12/01/01 to 11/30/02

Schedule 20A

XVIII. A. STAFFING AND SALARY COSTS
Line 32- Other Healthcare (specify)

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
	Care Plan Coordinator	1,538	1,600	$ 31,122	$ 19.45
	Medicare Coordinator	1,786	1,857	36,126	19.45
	Helping Hands/Nurs. Float.	7,328	7,621	41,152	5.40
32	**Total**	10,652	11,078	108,400	

See Accountants' Compilation Report

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ben Perkins	Administrator	0%	$ 84,843
Shannon Minshall	Asst. Administrator	0%	42,209
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,052

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
James Skinner	Legal	$ 332
SAAP County Fund	Legal	390
Clayton, Lloyd, Barhart, Beal Ltd.	Legal	32
Miller, Tracy, Braun, Funk & Guenther Ltd.	Legal	2,348
BKD LLP.	Accounting	24,425
Blucker, Kneer & Assoc.	Accounting	5,250
American Health Care Assoc.	Operations consulting	1,372
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,149

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 127,169
Unemployment Compensation Insurance	25,500
FICA Taxes	357,399
Employee Health Insurance	382,251
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	106,174
Employee Uniforms	30,825
Employee Morale	4,579
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,033,897

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,372
Health Care Worker Background Check	
(Indicate # of checks performed 336)	1,664
IHCA Dues	11,513
NAEIR Dues	1,215
Various Dues	617
Various Subscriptions	797
Various Licenses	266
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,444

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	8,126
Less: non-allowable costs	(1,471)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,655

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home
Provider #: 0010561
12/01/01 to 11/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	34,149
Non-allowable Legal Fees (collections)	(332)
Out of Period expenses	(407)
Non-allowable miscellaneous accounting services	(795)
Total (agree to Schedule V, line 19, column 8)	32,615

See Accountants' Compilation Report

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/01 Ending: 11/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5	N/A												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/01/01 **Ending:** 11/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn. - 11,513**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **68,596** Line **10 (2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **111,481**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,438**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Bluker, Kneer & Assoc. LTD** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Knox County Nursing Hc** **03:17 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	435,215	equal to	435,215	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	139,525	equal to	139,525	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,519	equal to	2,519	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	21,735	equal to	21,735	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	177,447	equal to	177,447	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	266,639	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,840,738	equal to	1,840,738	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,932,853	equal to	3,932,853	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,002,287	equal to	1,002,287	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	142,044	equal to	142,044	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	377,839	equal to	377,839	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	111,481	equal to	111,481	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,093,303	equal to	3,208,924	-115,621	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	21,735	-21,735	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	132,185	equal to	132,185	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	142,930	equal to	142,930	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	386,587	equal to	386,587	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	112,326	equal to	112,326	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	248,684	equal to	248,684	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	192,412	equal to	192,412	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	127,052	equal to	127,052	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	168,184	equal to	168,184	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,759,307	equal to	4,759,307	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,368	< or = to	8,368	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,200	< or = to	7,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	15,888	< or = to	19,746	-3,858	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,206	< or = to	2,206	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,206	< or = to	2,206	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	127,052	equal to	127,052	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	34,149	equal to	34,149	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,033,897	equal to	1,033,897	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	20,444	equal to	20,444	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,655	equal to	6,655	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	111,481	equal to	111,481	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	463,311	-463,311	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,923	equal to	3,923	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	489,428	equal to	489,428	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	156,600	equal to	156,600	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,471,197	equal to	3,471,197	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	825,162	equal to	825,162	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,147,520	equal to	3,147,520	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,765,265	equal to	2,765,265	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	189,482	equal to	189,482	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,162,983	equal to	3,162,983	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	386,587	31,925	8,368	426,880	0	426,880	0	426,880
2. Food P	0	366,288	0	366,288	0	366,288	-1,438	364,850
3. Housek	248,684	50,245	0	298,929	0	298,929	0	298,929
4. Laundry	192,412	28,637	0	221,049	0	221,049	0	221,049
5. Heat ar	0	0	224,615	224,615	0	224,615	0	224,615
6. Mainter	112,326	6,544	184,107	302,977	0	302,977	-324	302,653
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	940,009	483,639	417,090	1,840,738	0	1,840,738	-1,762	1,838,976
9. Medical	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursin	3,208,924	232,071	19,746	3,460,741	0	3,460,741	-2,538	3,458,203
10a. Ther	0	0	177,447	177,447	0	177,447	0	177,447
11. Activit	132,185	7,443	2,206	141,834	0	141,834	0	141,834
12. Social	142,930	495	2,206	145,631	0	145,631	0	145,631
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	3,484,039	240,009	208,805	3,932,853	0	3,932,853	-2,538	3,930,315
17. Admin	127,052	0	0	127,052	0	127,052	0	127,052
18. Direct	0	0	3,122	3,122	0	3,122	0	3,122
19. Profes	0	0	34,149	34,149	0	34,149	-1,534	32,615
20. Fees,	0	0	20,714	20,714	0	20,714	-270	20,444
21. Clerica	168,184	15,818	24,975	208,977	0	208,977	22,581	231,558
22. Emplo	0	0	570,586	570,586	0	570,586	463,311	1,033,897
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	8,126	8,126	0	8,126	-1,471	6,655
25. Other	0	0	4,983	4,983	0	4,983	0	4,983
26. Insura	0	0	24,578	24,578	0	24,578	0	24,578
27. Other	0	0	0	0	0	0	0	0
28. Total (	295,236	15,818	691,233	1,002,287	0	1,002,287	482,617	1,484,904
29. Total (	4,719,284	739,466	1,317,128	6,775,878	0	6,775,878	478,317	7,254,195
30. Depre	0	0	139,525	139,525	0	139,525	0	139,525
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	0	0	0	0	0	0
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	2,519	2,519	0	2,519	0	2,519
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	142,044	142,044	0	142,044	0	142,044
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	21,735	266,639	14,604	302,978	0	302,978	0	302,978
40. Barbe	18,288	1,149	0	19,437	0	19,437	0	19,437
41. Coffee	0	0	12,322	12,322	0	12,322	0	12,322
42	0	0	111,481	111,481	0	111,481	0	111,481
43. Other	0	0	43,102	43,102	0	43,102	-43,102	0
44. Total S	40,023	267,788	181,509	489,320	0	489,320	-43,102	446,218
45. Grand	4,759,307	1,007,254	1,640,681	7,407,242	0	7,407,242	435,215	7,842,457

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	759,209	759,209
2. Cash - F	0	0
3. Account	1,056,826	1,056,826
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	27,246	27,246
7. Other Pr	500	500
8. Account	0	0
9. Other (s	0	0
10. Total c	1,843,781	1,843,781
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	13,763	13,763
13. Land	0	0
14. Buildin	0	0
15. Leaseh	4,452,959	4,452,959
16. Equipn	0	0
17. Accum	########	########
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	0	0
24. Total L	1,319,202	1,319,202
25. Total A	3,162,983	3,162,983
CURRENT LIABILITIES		
26. Accour	140,492	140,492
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	223,783	223,783
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	14,879	14,879
37. Other (	18,564	18,564
38. Total C	397,718	397,718
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	0
46.Total Li	397,718	397,718
47.Total Eq	2,765,265	2,765,265
48.Total Li	3,162,983	3,162,983

		Balance per Medicaid Trial Balance
1.	Gross F	6,916,134
2.	Discour	-82,409
	Subtota	6,833,725
4.	Day Ca	0
5.	Other C	0
6.	Therapy	15,865
7.	Oxygen	9,468
	Subtota	25,333
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	11,790
13.	Barber	4,726
14.	Non-P	0
15.	Teleph	0
16.	Rental	0
17.	Sale o	72,749
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	65,435
22.	Laund	0
	Subtot	154,700
24.	Contril	3,776
25.	Interes	4,261
	Subtot	8,037
27.	Other	29,012
28.	Other	545,917
	Subtot	574,929
30.	Total F	7,596,724
31.	Gener	1,840,738
32.	Health	3,932,853
33.	Gener	1,002,287
34.	Owner	142,044
35.	Specia	377,839
35.	Provid	111,481
37.	Other	0
40.	Total E	7,407,242
41.	Incom	189,482
42.	Incom	0
43.	Net In	189,482

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Line 16 for mortgage insurance.